85-2152

Supreme Court, U.S.
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No. ———

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

FAYE S. BAGGIANO, IN HER OFFICIAL CAPACITY AS COMMISSIONER OF THE ALABAMA MEDICAID AGENCY, AND THE ALABAMA MEDICAID AGENCY,
Petitioners,

v.

ALACARE, INC.-NORTH, AN ALABAMA CORPORATION,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW[1]

The owner of a nursing home filed an action in federal court under 42 U.S.C. § 1983, challenging a decision of the Alabama Medicaid Agency denying the home a provider contract under the Medicaid program, 42 U.S.C. § 1396a. Concurrent with commencing the federal action, the nursing home appealed the identical decision to state circuit court pursuant to rules of the Alabama Medicaid Agency. Finding that exhaustion of state remedies was consistent with the statutory framework of the federal Medicaid Act, the federal district court dismissed the federal action for failure to exhaust state remedies. The Court of Appeals reversed, in part, finding that neither exhaustion of administrative remedies nor exhaustion of judicial remedies could be implied from the Medicaid Act. The questions presented for review are:

1. Whether, as a prerequisite to filing suit under 42 U.S.C. § 1983, claimants under the Medicaid Act, 42 U.S.C. § 1396a, must exhaust state administrative or other remedies established in compliance with the Medicaid Act.

2. Whether the existence of proceedings in state court commenced pursuant to rules of a state Medicaid agency charged by the Medicaid Act to administer the Medicaid program, preclude the commencement of duplicative proceedings in federal court under 42 U.S.C. § 1983.

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[1] The parties to the proceedings in the Eleventh Circuit Court of Appeals were Petitioners, the Alabama Medicaid Agency, which is the acting state agency which administers the Medicaid program in the State of Alabama under 42 U.S.C. § 1396a, the Commissioner of the Alabama Medicaid Agency, Faye S. Baggiano, in her official capacity, and Respondent, Alacare, Inc.-North, an Alabama corporation.

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Petitioners,

v.

ALACARE, INC.-NORTH, AN ALABAMA CORPORATION,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

The Petitioners, Faye S. Baggiano, in her official capacity as Commissioner of the Alabama Medicaid Agency, and the Alabama Medicaid Agency, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit entered in these proceedings on April 2, 1986.

OPINIONS BELOW

The opinion and order of the court of appeals affirming in part, and reversing in part, the judgment of the district court and remanding for trial is reported at 785 F.2d 963 (11th Cir. 1986). The opinion and order is attached hereto as Appendix A.

The opinions and orders of the district court are attached hereto as Appendices C and D.

JURISDICTION

The judgment of the court of appeals was entered on April 2, 1986 (see Appendix A). This Petition for Certiorari was filed within 90 days after that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

1. 42 U.S.C. § 1983 (Appendix E)
2. 42 U.S.C. § 1396a (Appendix F)
3. Alabama Medicaid Administrative Code, Rules 560-X-3-.01 through 560-X-3-.07 (Appendix G)
4. *Ala. Code* § 41-22-20 (1975) (Appendix H)

STATEMENT OF THE CASE

AlaCare, Inc.-North (hereinafter referred to as "AlaCare") operates the Adams Nursing Home in Tallapoosa County, Alabama. Prior to 1984, Adams Nursing Home served as a provider of intermediate care nursing services under Title XIX of the Social Security Act (the Medicaid Act), pursuant to a contract with the Alabama Medicaid Agency. During 1984, AlaCare sought certification to provide skilled care services and become a "dual-care provider" of both intermediate and skilled care services under the Medicaid program. Faye S. Baggiano, acting in her official capacity as Commissioner of the Alabama Medicaid Agency, denied AlaCare's request for a dual-care contract because of the existence of a surplus of skilled care beds in Tallapoosa County. Denial of a con-

tract for good cause is permitted by 42 C.F.R. § 442.12 (d) (1985).

AlaCare requested, and received, an administrative hearing on the Agency's decision. An impartial hearing officer recommended approval of the Agency's decision and the Agency concurred. Subsequently, AlaCare filed an appeal to state circuit court in accordance with Rule 560-X-3-.06 of the Alabama Medicaid Administrative Code (Appendix G) and the Alabama Administrative Procedure Act, *Ala. Code* § 41-22-20 (1975) (Appendix H).[2] Concurrent with the pursuit of the state remedy, AlaCare filed this civil action in federal district court on March 1, 1985, under 42 U.S.C. § 1983 and 28 U.S.C. § 1331, against the Alabama Medicaid Agency and Commissioner Baggiano in her official capacity, challenging the identical decision which AlaCare was appealing in state circuit court.

On March 26, 1985, the Alabama Medicaid Agency and Commissioner Baggiano filed separate motions to dismiss the federal action on the grounds that, *inter alia*, AlaCare had failed to exhaust state remedies which AlaCare was then pursuing. The Agency and the Commissioner maintained that although under this Court's decision in *Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496 (1982), exhaustion of state remedies is generally not required under § 1983, *Patsy* also recognized that exhaustion might be required where consistent with congressional intent. The district court treated the motions as ones for summary judgment and granted the motions on May 3, 1985. Recognizing that the Medicaid Act requires participating states to administer the Medicaid program within the state and that the Act requires a state

[2] The State case is now pending before the Alabama Court of Civil Appeals, Case No. CV-5378, on the appeal of the Alabama Medicaid Agency, and the cross-appeal of AlaCare, from a judgment of the Circuit Court of Tallapoosa County, Alabama.

administrative review procedure, the district court held that the Medicaid Act created an exception to the general rule that litigants need not exhaust state remedies prior to filing an action under 42 U.S.C. § 1983, and that state remedies contemplated by the Medicaid Act should be pursued as a first resort:

> In light of the administrative framework established under the Medicaid Act, the Court is of the opinion that plaintiff [AlaCare] should pursue the remedies provided by state law before instituting an action in federal court.

(Appendix C). AlaCare filed a motion for reconsideration of the district court's order granting judgment in favor of Commissioner Baggiano on May 15, 1985, which was denied on June 28, 1985 (Appendix D).[3]

AlaCare appealed the district court's order granting judgment in favor of Commissioner Baggiano and the Alabama Medicaid Agency to the Court of Appeals for the Eleventh Circuit. On April 2, 1986, the Eleventh Circuit Court of Appeals affirmed in part, and reversed in part, the decision of the district court and ordered that the case be remanded for trial. The court of appeals ruled that neither exhaustion of state administrative remedies nor exhaustion of judicial remedies could be implied under the Medicaid Act. Finding irreconciliation between this Court's decision in *Patsy* and this Court's decision in *Fair Assessment in Real Estate Association v. McNary*, 454 U.S. 100 (1981), the court of appeals primarily relied on this Court's decision in *Rosado v. Wyman*, 397 U.S. 397 (1970).

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[3] The District Court for the Middle District of Alabama considered this issue again in the case of *Hamilton v. Baggiano*, Civil Action No. 85-H-805-N (M.D. Ala. Sept. 3, 1985) and again held that a requirement of exhaustion of administrative remedies could be construed from the Medicaid Act.

REASONS FOR GRANTING THE WRIT

I. The Decision Below Raises An Important Question Of Federal Law On Which Federal Courts Are In Disagreement And Which Concerns The Administration Of All Claims Under The Medicaid Act And Federal Jurisdiction Of Such Claims Under 42 U.S.C. § 1983.

The central issue in this case is whether a claimant under Title XIX of the Social Security Act, 42 U.S.C. § 1396a (the Medicaid Act) as a prerequisite to filing suit in federal court under 42 U.S.C. § 1983, must exhaust state administrative review procedures which, by mandate of Congress, participating states are required to implement. A related issue in this case, which, as the court of appeals explains, depends upon the result reached in the first question is whether an exhaustion requirement or abstention should apply in federal court when an appeal is pending in state court from an administrative decision of the state Medicaid Agency involving identical claims under the Medicaid Act.

The decision of the Eleventh Circuit Court of Appeals makes this case one of dual significance. First, it raises again the question of the contours of this Court's decision in *Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496 (1982), wherein this Court addressed at length the general rule that a plaintiff is not required to exhaust administrative remedies prior to filing a civil rights action under 42 U.S.C. § 1983. The court of appeals admits that the *Patsy* decision is "somewhat opaque" on the question of how much congressional direction is necessary to establish an exception to the general no-exhaustion rule. *AlaCare, Inc.-North v. Baggiano*, 785 F.2d 963, 965 (11th Cir. 1986). Second, the court of appeals' decision significantly alters the manner in which *all* states administer claims under the Medicaid Act and similarly organized federal-state government welfare programs.

The Medicaid program includes not only the Medicaid Act, but also numerous and all-encompassing federal

rules and regulations with which participating states must comply. *See*, generally, 42 C.F.R. §§ 430-456 (1985). It is conceivable that a complainant could challenge any state agency error as violative of one of these provisions. Consequently, the decision of the court of appeals presents an opportunity for every applicant for financial assistance under any state's Medicaid program whose application is denied to immediately file a civil action against the state Medicaid Agency in federal court, even though the Medicaid Act itself requires the participating state to afford these applicants an impartial administrative review process. *See*, 42 U.S.C.A. § 1396a (a) (3) (West 1983). The adverse effect of a state having to defend every decision on either an applicant's eligibility for Medicaid or a medical provider's request to participate in the Medicaid program is economically and logistically enormous when compared to the administrative review process Congress requires participating states to make available. The consequences of the decision of the court of appeals, as further discussed herein, and the fact that every state in the Union which participates in the federal Medicaid program is faced with this identical issue, makes this question one of substantial importance which is in need of determination by this Court.

In this Court's last major pronouncement that exhaustion of administrative remedies is generally not a prerequisite to filing a federal lawsuit under 42 U.S.C. § 1983, this Court ruled that the question was primarily one of congressional intent. *Patsy, supra.* In *Patsy*, this Court stated that although an exhaustion requirement must be consistent with congressional legislation, the exhaustion requirement need not be explicit:

> Even where the statutory requirement of exhaustion is not explicit, courts are guided by congressional intent in determining whether application of the doctrine would be consistent with the statutory scheme . . . with state administrative remedies, the focus is

> not so much on the role assigned to the state agency, but the role of the state agency becomes important once a court finds that deferring its exercise of jurisdiction is consistent with statutory intent.

Patsy, 457 U.S. at 501-502 (1982). In addition, the *Patsy* decision affords weight to policy considerations in the event that exhaustion is consistent with congressional intent. *Id.* at 513. Nevertheless, some courts have construed the *Patsy* decision to create an extremely rigid rule with little or no room for exception except for explicit directive of Congress. *See, e.g., Lewis v. Hillsborough Transit Authority*, 726 F.2d 668, 669, (11th Cir. 1984); *Heath v. Cleary*, 708 F.2d 1376, 1379 (9th Cir. 1983); *Johnson v. King*, 696 F.2d 370, 371 (5th Cir. 1983).

However, in opinions by members of this Court in *Fair Assessment in Real Estate Association v. McNary*, 454 U.S. 100 (1981), a decision rendered six months prior to *Patsy*, this Court also indicated that exhaustion may be implicitly discerned from congressional action or policy. In a case in which there was no controlling congressional authority requiring exhaustion, this Court in *McNary*, relying upon general congressional policy, dismissed claims under § 1983 which challenged the constitutionality of state tax laws because of pending state proceedings involving the same claim. Consistent with this ruling, Justice Brennan expressed in his concurring opinion that "where the obligation to require exhaustion of administrative remedies may be *fairly understood* from congressional action, or is in accord with congressional policy, not only is § 1983 no bar, but the federal courts should be alert to further these policies." *Id.* at 136 (emphasis added).

The Eleventh Circuit, admitting that it has difficulty reconciling *McNary* with *Patsy*, creates its own standard, "some clearly, evident indication from Congress . . ." that exhaustion of remedies is Congress' intent. *AlaCare, Inc.*-

North v. Raggiano, 785 F.2d at 969 (11th Cir. 1986)[4]. This standard appears no different from the "explicit directive" standard previously rejected by this Court in *Patsy*, and, in practice would surely prove the same. The confusion which has resulted in the attempts to reconcile *Patsy* and *McNary* warrants further review by this Court. As shown below, this question is particularly appropriate in the Medicaid context.

Medicaid is a cooperative federal-state medical assistance program in which participating states receive matching federal funds in reimbursing qualified "providers" of medical care for expenses incurred in treating eligible Medicaid recipients, 42 U.S.C.A. § 1396a (West 1983). The Medicaid Act specifically provides for management and administration of the Medicaid program within a participating state by the appropriate state agency and clearly requires the establishment of a state administrative scheme in which individuals who are denied requests for assistance under the program are provided an opportunity for an administrative fair hearing, 42 U.S.C.A. § 1396(a)(3) (West 1983).

Each participating state is required by the Medicaid Act and the federal regulations of the Department of Health and Human Resources to enact rules and procedures for implementing the program which conform to federal law and to administer and supervise the application of those rules, 42 U.S.C.A. § 1396a(a)(1-5) (West 1983); 42 C.F.R. §§ 430-456 (1985). In compliance with the federal Medicaid Act and the federal regulations, the State of Alabama has established the Alabama Medicaid

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[4] The inconsistencies between the decisions in *Patsy v. Board of Regents of the State of Florida*, *supra*, and *Fair Assessment, etc. v. McNary*, *supra*, are discussed at length in an article published in the DePaul Law Review. *See*, Comment, "A Rigid No-Exhaustion Rule for Section 1983 Actions: *Patsy v. Board of Regents*," DePaul Law Review, Vol. 32, p. 185 (1983).

Administrative Code, which provides for an administrative hearing and decision process for claims under the program (Appendix G).

In accordance with the State rules, anyone seeking medical financial assistance under the Medicaid program must file an application with the Medicaid Agency for determining eligibility. Obviously, a significant part of the Medicaid program is the processing of these applications. When an application is denied, the impartial administrative review process affords a quick, efficient and economical means of resolving the denial. In addition, the administrative review process is consistent with congressional policy that the states operate the Medicaid program in a cost efficient manner.[5]

These circumstances, that Congress requires states participating in the Medicaid program to afford claimants an administrative review procedure, that an administrative review procedure is particularly appropriate for handling the numerous claims that necessarily arise under such programs, and that the administrative review procedure is consistent with the statutory policy of cost efficiency in operating Medicaid programs, would appear to inevitably lead to the conclusion that a requirement of exhaustion of administrative remedies in the Medicaid area is, in the terms of *Patsy*, "consistent with the statutory scheme," and, in the terms of Justice Brennan in *McNary*, "fairly understood from congressional action, or is in accord with congressional policy . . ." However, because of varying interpretations of the *Patsy* decision, federal courts have reached inconsistent results.

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[5] A state has an obligation to administer a Medicaid program in an economically efficient manner so to prevent wasteful allocation of resources. *See, Mississippi Hospital Association v. Heckler*, 701 F.2d 511, 518 (5th Cir. 1983); *Illinois Hospital Association v. Illinois Department of Public Aid*, 576 F. Supp. 360, 362 (D. Ill. 1983). *See, also*, 42 U.S.C.A. §1396a(a)(30) (West 1983). Penalties may be imposed against a state for failure to safeguard against wasteful allocation of resources. *See*, 42 C.F.R. §§ 456.1-456.657.

The several federal district courts which have attempted to interpret the Medicaid Act and other similar programs in the light of the *Patsy* decision have split on the question of whether exhaustion of administrative remedies is required. The decisions which recognize an exception to the no-exhaustion rule are: *AL-Charles, Inc. v. Heintz*, 620 F. Supp. 327 (D. Conn. 1986) (Medicaid); *Arden House, Inc. v. Heintz*, 612 F. Supp. 81 (D. Conn. 1985) (Medicaid); *St. Joseph Hospital v. Electronic Data Systems Corp.*, 573 F. Supp. 443 (S.D. Tex, 1983) (Medicaid); *Ryans v. New Jersey Commission for the Blind*, 542 F. Supp. 841 (D. N.J. 1982) (Title I, Rehabilitation Act of 1973); *Hamilton v. Baggiano*, Civil Action No. 85-H-805-N (M.D. Ala. Sept. 3, 1985) (Medicaid). The decisions holding that exhaustion of administrative remedies is not required are: *In Re: Greenwald*, 48 Bankr. 263 (S.D. N.Y. 1984) (Medicaid); *Quakertown Hospital Association v. O'Bannon*, 1983 Medicare & Medicaid Guide (CCH) ¶ 33,629 (E.D. Pa. 1983) (Medicaid); *Walker v. Adams*, 578 F. Supp. 50 (W.D. Ky. 1983), *aff'd on other grounds*, 741 F.2d 116 (6th Cir. 1984) [Aid to Families With Dependent Children Act, 42 U.S.C.A. §§ 601-621 (West 1983)]. All of these decisions involve Medicaid or a similar government welfare program in which the states are charged by Congress to administer the program and to provide an administrative review process. Each decision purports to reconcile its ruling with the decision in *Patsy*, yet the courts reach opposite conclusions. These conflicting rulings evidence the confusion on this important issue. The court of appeals' decision below only adds to this confusion.

In addition to the court of appeals admitting its inability to reconcile the decisions in *Patsy* and *McNary*, the court of appeals clearly erred in its principal reliance on an inapplicable decision of this Court, *Rosado v. Wyman*, 397 U.S. 397 (1970). Terming *Rosado* as the "clearest basis" for holding that there is no implicit ex-

ception to the no-exhaustion rule under the Medicaid Act, the court of appeals attributes to this Court a ruling that under the Aid to Families With Dependent Children Act ("AFDC"), 42 U.S.C.A. §§ 601-621 (West 1983), a government reimbursement program similar in organization to Medicaid, there is no exhaustion requirement. *AlaCare, Inc.-North* at 968. Although the court of appeals is correct in noting that the organizational and administrative structures of the two programs are similar, the court of appeals is wrong in assuming that the claims in *Rosado* were the type that could have been reviewed under the AFDC administrative review procedure. In *Rosado*, this Court clearly stated that there was no applicable administrative mechanism. *Rosado*, 397 U.S. at 406, n.8. In response to the state's argument that the claimants should be required to first pursue their claims administratively, this Court stated:

> Petitioners answer, we think correctly, that neither the principle of 'exhaustion of administrative remedies' nor the doctrine of 'primary jurisdiction' has any application to the situation before us.

397 U.S. at 406.

Plainly, the court of appeals in its decision below was in error in likening this case to the situation presented in *Rosado* and in citing that decision for support of its ruling that exhaustion is not required under the Medicaid Act. As mentioned above, this error only adds to the existing confusion surrounding the issue in this case.

As evidenced by the conflicting decisions, this question of exhaustion is not limited to the Medicaid Act, but also includes nearly every cooperative federal-state program which requires the state to administer the program and to create an administrative review process. [*See, e.g.*, Title I of the Rehabilitation Act of 1973, 29 U.S.C.A. § 722(d) (West 1985); Aid to Families with Dependent Children Act, 42 U.S.C.A. §§ 601-621 (West 1983).] Each program involves the processing of numerous ap-

plications for government assistance, some of which will surely be denied. Whether claims based on those denials must first be pursued administratively is an issue that substantially affects the operation of all these programs throughout the country, not just Medicaid.

The court of appeals' decision will allow every claimant in routine provider reimbursement disputes or eligibility disputes to short-circuit the state agency's administrative review process with a federal lawsuit. The decision will, in the words of one federal court, reduce the congressionally required state administrative review procedure to a "meaningless charade". See, *St. Joseph Hospital v. Electronic Data Systems*, 573 F.Supp. 443, 450 (S.D. Tex. 1983). Not only does the federal case load stand to be greatly increased, but state agencies will be required to expend inordinate time and money in defending their decisions in federal courts.

Furthermore, it is not unreasonable to assume that every claimant who prevails against the state Medicaid Agency on a claim under 42 U.S.C. § 1983 will seek a sanction of attorneys fees under 42 U.S.C. § 1988. Thus, by providing all applicants and providers immediate resort to federal court, the court of appeals' decision creates a situation in which the Medicaid Agency will incur a substantial penalty for failure to operate an error-free program.

As a result, penalties will be imposed for errors made in the initial denial of an application even though the agency's existing review process is never given an opportunity to correct such errors. Realistically, in order to minimize these penalties, every application will have to pass through all channels of review, including the agency's director, Commissioner Baggiano in this case, before any initial decision can be made. The administrative and managerial burden and attendant great expense in processing every application through the entire chain of command will be enormous. In this regard, it must be noted

that the Medicaid Act recognizes that an applicant may make a claim against the state agency for failure to process an application with reasonable promptness. *See*, 42 U.S.C.A. §§ 1396a(a)(3), (8) (West 1983). That the extra effort expended in processing applications in order to avoid federal lawsuits could, in itself, lead to further lawsuits, illustrates the anomaly created by the court of appeals' decision. Certainly, the decision of the court of appeals will result in the channeling of substantial funds into the administration of the program rather than to medical services for needy recipients.

In conclusion, the question whether exhaustion of administrative or other remedies is required under the Medicaid Act is one which has substantial impact on the operation of many federal-state cooperative welfare programs in every state in the Union. The several federal district courts which have considered this issue in light of this Court's decision in *Patsy v. Board of Regents of the State of Florida*, *supra*, reach opposite and conflicting decisions. Even the decision of the Eleventh Circuit recognizes the irreconciliation of this issue. Because this question is of great importance to many government welfare programs, impacts on federal jurisdiction, and is an issue upon which federal courts are in disagreement, this issue should be determined by this Court.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT

No. 85-7420

ALACARE, INC.—NORTH, an Alabama corporation,
Plaintiff-Appellant,

v.

FAYE S. BAGGIANO, in her official capacity as commissioner of the Alabama Medicaid Agency,
Defendant-Appellee,

and

ALABAMA MEDICAID AGENCY,
Defendant.

April 2, 1986

Appeal from the United States District Court
for the Middle District of Alabama

Before JOHNSON and HATCHETT, Circuit Judges, and MURPHY*, District Judge.

JOHNSON, Circuit Judge:

In *Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982),

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* Honorable Harold L. Murphy, U.S. District Judge for the Northern District of Georgia, sitting by designation.

the Supreme Court determined that there is no general exhaustion of remedies requirement for plaintiffs pursuing claims under 42 U.S.C.A. § 1983 (1985). This Circuit has not previously attempted to mark the precise contours of that holding. We hold today that *Patsy* does not preclude the finding of implicit exhaustion requirements in congressional enactments. But we also hold that no such requirement exists under the language of the Medicaid Act, 42 U.S.C.A. § 1396, *et seq.* (1985). Accordingly, we AFFIRM in part and REVERSE AND REMAND in part the holding of the trial court below.

I.

This is an action brought under Section 1983 by a provider of health care services under the Medicaid Act. Medicaid is a cooperative endeavor of the state and federal governments. Each state is required, consistent with basic federal guidelines, to create its own administrative rules and regulations for running the program in that state through a specially created state agency. Each state must also set up an administrative review process, but is not required to provide for state judicial review.

Appellant Alacare Inc.-North ["Alacare"] operates the Adams Nursing Home in Alexander City, Tallapoosa County, Alabama. Prior to 1984 appellant's nursing home was certified under the Medicaid Act as an "intermediate care provider"—a level of care higher than mere room and board, but not as high as that provided by a "skilled care provider." The services provided by the latter are equivalent to those one could receive as a hospital in-patient. Those facilities certified to provide both intermediate and skilled care are called "dual care providers." The financial reimbursement from the federal government through the states is higher for skilled care than for intermediate care.

Appellant resolved to secure all necessary certification and licenses in order to operate as a dual care provider.

It received the necessary federal and state documents as of February 1, 1984, but the appellee, Faye S. Baggiano, acting in her official capacity as Commissioner of the Alabama Medicaid Agency, refused to issue a dual care provider contract to the appellant for the contract year 1985-86. She based this on the existence of a surplus of skilled care beds in Tallapoosa County. Denial of a contract for good cause is permitted by 42 C.F.R. § 442.12 (d) (1984). The United States Department of Health and Human Services reviewed this decision, upon appellant's request, and approved the appellee's determination that Alacare should not be issued a dual care provider contract.

Appellant claims that this decision was without good cause, arbitrary, and capricious, in that Alacare has obtained all the necessary federal and state clearances save the contract. It claims that one offered justification—budgetary considerations—is in unlawful noncompliance with federal standards as proscribed by *Alabama Nursing Home Ass'n v. Califano*, 433 F.Supp. 1325, 1330 (M.D.Ala. 1977). Appellant has exhausted all state administrative remedies, and is currently in the process of pursuing its state judicial remedies as provided by Ala. Code § 41-22-20(a) (1975).

Concurrent with the pursuit of a state judicial remedy, Alacare filed this action on March 1, 1985, under Section 1983 for wrongful failure and refusal to contract with appellant as a dual care provider. Appellee Baggiano and defendant Alabama Medicaid Agency ["AMA"] filed motions to dismiss alleging, *inter alia*, failure to exhaust available remedies with the state. The trial court considered the motion to dismiss as a motion for summary judgment and granted that motion on May 3, 1985, due to failure to exhaust state remedies.

Alacare filed a motion to reconsider as to Baggiano, but not AMA. This was denied in an order entered June 28, 1985, the trial court finding that Alacare "has failed

to show that the exhaustion requirement should be waived in this case." Alacare appeals only as to the summary disposition of its suit against Baggiano.

II.

This case raises two issues: A) whether the trial court properly found an implied requirement in the Medicaid Act to exhaust state remedies before pursuing a Section 1983 action in federal court; and B) if that requirement is proper, whether the trial court erred here in requiring exhaustion of both state administrative and judicial remedies.

A. Exhaustion Requirements:

The appellant argues that the trial court was in error in finding an implied exhaustion requirement for Medicaid actions under Section 1983; this poses a question of law. Neither party contests any factual issues here. Consequently, our review is independent. *Cathbake Inv. Co. v. Fisk Electric Co.*, 700 F.2d 654, 656 (11th Cir. 1983).

1) *Implicit and Explicit Exhaustion Requirements:*

In *Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982), the Supreme Court strongly reaffirmed that there is no general requirement that a plaintiff exhaust any remedy he might have at state law before proceeding into federal court, save where Congress has crafted an exception to that general rule. *Id.* at 512, 102 S.Ct. at 2565-66. The language of *Patsy* is, however, somewhat opaque on the question whether this congressionally created exception must be explicitly supplied or may be deemed implicit in the type of administrative machinery Congress constructs.

Alacare points to portions of Justice Marshall's Opinion for the Court that note how narrowly and clearly

Congress created the only major exception to the no-exhaustion rule.[1] From this appellant argues that *Patsy* must be read as imposing what Justice Powell called "a flat rule without exception." 457 U.S. at 534 (Powell, J., dissenting). Unless the Congress created a specific, and explicit, exception, appellant argues, a court may not find one.

The appellee, and the trial court below, note several passages in *Patsy* that contradict this. The Supreme Court recognized that "[o]f course, courts play an important role in determining the limits of an exhaustion requirement and may impose such a requirement even where Congress has not expressly so provided." 457 U.S. at 501, 102 S.Ct. at 2560. *Patsy*'s footnote 4 elaborates on this theme:

> Even where the statutory requirement of exhaustion is not explicit, courts are guided by congressional intent in determining whether application of the doctrine would be consistent with the statutory scheme . . . . With state administrative remedies, the focus is not so much on the role assigned to the state agency, but the role of the state agency becomes important once a court finds that deferring its exercise of jurisdiction is consistent with statutory intent.

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[1] "The legislative history of [the Civil Rights of Institutionalized Persons Act, 42 U.S.C.A. § 1997 *et seq.* (1985) ["CRIPA"]] demonstrates that Congress has taken the approach of carving out specific exceptions to the general rule. . . ." 457 U.S. at 512, 102 S.Ct. at 2565. The creation of a "detailed scheme [as with CRIPA] is inconsistent with discretion to impose, on an ad hoc basis, a judicially developed exhaustion rule in other cases." 457 U.S. at 511, 102 S.Ct. at 2565. "Implicit in this decision [to enact CRIPA] is Congress' conclusion that the non-exhaustion rule should be left standing with respect to other § 1983 suits." *Id.* at 509, 102 S.Ct. at 2564. "In [CRIPA] Congress also created a specific, limited exhaustion requirement . . . ." *Id.* at 508, 102 S.Ct. at 2563.

457 U.S. at 502, n. 4, 102 S.Ct. at 2560 n. 4. In determining whether putatively impilcit exceptions in fact exist, we must look always "to congressional intent; and a court should not defer the exercise of jurisdiction under a federal statute unless it is consistent with that intent." *Id.* at 501-02, 102 S.Ct. at 2560.

Patsy cannot be read quite so broadly as Alacare would like; nor can footnote 4 be applied quite as the trial court would have it. The effect of the former would be to render footnote 4 surplusage; affirming the trial court's holding *in toto* would place on the courts the burden of making a number of policy choices as to the scope and contours of exceptions for which the Supreme Court felt legislative solutions were preferable. *Patsy*, 457 U.S. at 513-14, 102 S.Ct. at 2566-67.

Adopting a broad reading of *Patsy* would exacerbate a tension that the Supreme Court created by failing to reconcile that case with *Fair Assessment in Real Estate Ass'n v. McNary*, 454 U.S. 100, 102 S.Ct. 177, 70 L.Ed.2d 271 (1981). The Court in *McNary* held that, notwithstanding the no-exhaustion principles announced in *McNeese v. Board of Education*, 373 U.S. 668, 83 S.Ct. 1433, 10 L.Ed.2d 633 (1963), and its progeny, a Section 1983 action would not lie against a state tax assessor unless plaintiffs had first sought "protection of their federal rights by state remedies. . . ." 454 U.S. at 116, 102 S.Ct. at 186. More important for this case is the language of Justice Brennan, concurring in the judgment for himself and Justices Marshall, Stevens, and O'Connor. *Id.* at 117, 102 S.Ct. at 186-87. Where the requirement of exhaustion merely defers, rather than displaces, the Section 1983 remedy, there need not be a "clear statement of congressional intent. . . ." Rather, "a somewhat lesser showing is required. . . . Where the obligation to require exhaustion of administrative remedies may be *fairly understood* from congressional action, or is in accord with congressional policy, not only is § 1983 no bar,

but the federal courts should be alert to further those policies." *Id.* at 136, 102 S.Ct. at 196 (emphasis supplied). This came in the context of a state tax dispute, an area in which federal courts have long been reticent to intervene, but we find no basis in the language of the various opinions in *McNary* for limiting that holding to the tax context. Notwithstanding Justice Powell's dissent in *Patsy*, we are unable to reconcile *Patsy* and *McNary* except by holding that *Patsy* is *not* a flat statement that no exhaustion can be required except upon explicit congressional provision.[2] To that extent, the trial court in this case was correct.

The Supreme Court was not willing to foreclose completely the existence of exceptions by implication. The Court's statement that "Congress has taken the approach of carving out specific exceptions" to the rule does not require holding that courts may never find implied exceptions; it merely suggests that we must be chary of doing so absent compelling evidence to suggest that Congress truly did so intend. The question then becomes whether there is any firm evidence of congressional intent to require exhaustion of state remedies in Medicaid cases.

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[2] The Sixth Circuit has also recognized the tension between the holdings in *Patsy* and *McNary* in a case involving a claim under the Ohio civil service law:

> We note that the *Patsy* decision is not easily reconcilable with the Court's earlier decision in [*McNary*], where the Court left open the possibility of exceptions to the no-exhaustion requirement. While we believe that *Patsy* has not precluded the possibility of fashioning future exceptions to the no-exhaustion rule, we find that such an exception would be inappropriate in the instant cases. . . . Nor do we believe that the instant actions fall within the range of exceptions contemplated by Justice Brennan in his concurrence in [*McNary*].

Loudermill v. Cleveland Board of Education, 721 F.2d 550, 555 n.5 (6th Cir. 1983), *aff'd on other grounds*, —— U.S. ——, 105 S.Ct. 1487, 84 L.Ed.2d 494 (1985).

2) *A Medicaid Exception:*

Patsy leaves no doubt that the presumption is *strongly* in favor of no exception. 457 U.S. at 513, 102 S.Ct. at 2566. The more firmly we restrain ourselves, absent a clear cue from Congress, the better. The evidence of a congressional preference for imposing an exhaustion requirement in Medicaid cases is simply inevident, either explicitly or implicitly.

A number of courts have been presented with Section 1983 claims under the Medicaid Act. Until recently they uniformly have allowed the plaintiffs to go forward without requiring exhaustion of state remedies. *Curtis v. Taylor*, 625 F.2d 645, 649 (5th Cir.), *modified on other grounds*, 648 F.2d 946 (5th Cir.1980); *Randall v. Lukhard*, 709 F.2d 257, 261 (4th Cir.1983), *aff'd and rev'd in part on other grounds*, 729 F.2d 966 (4th Cir.) (*en banc*), *cert. denied*, —— U.S. ——, 105 S.Ct. 222, 83 L.Ed.2d 152 (1984); *Illinois Hospital Ass'n v. Illinois Dep't of Public Aid*, 576 F.Supp. 360, 367 (N.D.Ill.1983); *Thomas v. Johnson*, 557 F.Supp. 879, 902 (W.D.Tex. 1983). The problem is that these courts were not squarely presented with the question whether exhaustion should be required. They simply did not require it.

Several district courts have considered the question expressly since the decision in *Patsy*, and they have split. Those finding that Medicaid does not impose an exhaustion requirement are: *In re Greenwald*, 48 B.R. 263, 270-71 (S.D.N.Y.1984); and *Quakertown Hospital Ass'n v. O'Bannon*, 1983 Medicare & Medicaid Guide (CCH) ¶ 33,629 (E.D.Pa.1983). Those reaching contrary results are: *Arden House, Inc. v. Heintz*, 612 F.Supp. 81, 85 (D.Conn.1985); *St. Joseph Hospital v. Electronic Data Systems Corp.*, 573 F.Supp. 443, 450 (S.D.Tex.1983); and *Ryans v. New Jersey Commission for the Blind*, 542 F.Supp. 841, 850 (D.N.J.1982).

Those courts holding that there is an implicit exhaustion requirement base that conclusion on the fact that the Medicaid statute requires the creation of a state administrative process to review claims. They reasoned that if Congress ordered these avenues set up it must, *a priori*, have intended that they be used to weed out most of the claims, thereby limiting the burden on the federal court system. On the surface, this is a not unreasonable assumption. But we conclude that it is unavailing for three reasons.

First, we must always bear in mind the purpose Congress had in adopting Section 1983: to provide an alternate, *supplemental* avenue for relief to persons who almost always have an additional available remedy at state law. *Monroe v. Pape*, 365 U.S. 167, 183, 81 S.Ct. 473, 482, 5 L.Ed.2d 492 (1961); *Hudson v. Palmer*, —— U.S. ——, ——n.9, 104 S.Ct. 3194, 3210 n.9, 82 L.Ed.2d 393 (1984) (Stevens, J. concurring and dissenting); *Patsy v. Florida International Univ.*, 634 F.2d 900, 916 (5th Cir. 1981) (*en banc*) (Rubin, J., dissenting), *rev'd*, 457 U.S. 496, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982). Further, Congress has expressed its desire to maintain "free, unimpeded resort to 1983." *Patsy*, 457 U.S. at 509, 102 S.Ct. at 2564 (quoting remarks of Rep. Kastenmeier in debate over CRI-PA). In almost any case brought under Section 1983 there will be some sort of administrative or judicial avenue of relief at state law—whether compelled by federal statute or simply available under general state court jurisdiction. Thus the mere fact that Congress created parallel and perhaps duplicative avenues for review does not, standing alone, demonstrate an implicit purpose to impose an exhaustion requirement.

The second, and clearest, basis for holding that there is no implicit exception for the Medicaid Act is simply to compare it with the Aid to Dependent Children Act, 42 U.S.C.A. § 601 *et seq.*, (1985) ["ADC"], where the Supreme Court has held that Congress *did not* craft an

exhaustion requirement, and with CRIPA, an instance where the Congress specifically *did* create an exception. The Medicaid Act sets up a dual federal-state program, mandates the creation of a state administrative agency, and provides for "granting an opportunity for a fair hearing before the State agency to any individual whose claim . . . is denied or is not acted upon with reasonable promptness. . . ." 42 U.S.C.A. § 1396a(a)(3). ADC is also a program run as a joint federal-state endeavor, also requires that each state set up an administrative agency, and also requires that the agency "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim . . . is denied or is not acted upon with reasonable promptness. . . ." 42 U.S.C.A. § 602(a)(4). The similarity in the structure of the two programs is striking; the language providing for administrative review is identical. The Supreme Court has held that there is no exhaustion requirement under ADC. *Rosado v. Wyman*, 397 U.S. 397, 405-07, 90 S.Ct. 1207, 1214-15, 25 L.Ed.2d 442 (1970) (exhaustion not required, though federal court need not "deprive itself of the benefit of the expertise of the federal agency" if available in the form of *amicus* brief or published interpretation of rules, etc.).[3]

On the other hand, CRIPA does *not* create a separate administrative agency, but requires that to the extent there exists "a plain, speedy, and effective system for the resolution of grievances . . ." it must be resorted to absent certain circumstances. 42 U.S.C.A. § 1997e. Clearly the similarity among the three programs is between Medicaid and ADC. This suggests strongly that the exception that exists for CRIPA, and does not exist for ADC, is not implicit in Medicaid.

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[3] Since the decision in *Patsy* at least one court has reaffirmed that ADC does not require exhaustion before bringing a Section 1983 action. *Walker v. Adams*, 578 F. Supp. 50, 52 (W.D. Ky. 1983), *aff'd on other grounds*, 741 F.2d 116 (6th Cir. 1984).

The third reason we reject the trial court's finding of an exhaustion requirement is based on logic and practicality. If we were to endorse the trial court's reasoning as to Medicaid, we see no principled basis for limiting that holding. The result would be a major, dramatic narrowing of the scope of relief available under Section 1983. If that were the appropriate interpretation to accord the statutory provision of administrative review, we doubt that the Supreme Court in *Patsy* would have been so forceful in identifying the CRIPA exception as so exceptional. "It is not for us to say whether Congress will or should create a similar scheme for other categories of § 1983 claims or whether Congress will or should adopt an altogether different exhaustion requirement for non-prisoner § 1983 claims." 457 U.S. at 515. Save for cases like *McNary*, this statement could be read as suggesting that CRIPA is *the only* exception to the general rule.

If the statutes excepted from the no-exhaustion rule were as common as would be required under the trial court's approach, the Supreme Court would have made mention. Yet *Patsy* and other cases leave no doubt that the CRIPA exception is a rare creature indeed. *See, e.g., Lewis v. Hillsborough Transit Authority*, 726 F.2d 668, 669 (11th Cir.) (*per curiam*) (denying petition for rehearing) (" 'Exhaustion of state judicial or administrative remedies is not a prerequisite to section 1983 actions, except for those cases falling under the narrow exhaustion scheme embodied in [CRIPA]' " (citation omitted) (quoting *Daniels v. Williams*, 720 F.2d 792, 794 n.1 (4th Cir.1983), *aff'd on other grounds*, 748 F.2d 229 (4th Cir. 1984) (*en banc*), *cert. granted*, —— U.S. ——, 105 S.Ct. 1168, 84 L.Ed.2d 320 (1985)), *cert. denied*, —— U.S. ——, 105 S.Ct. 95, 83 L.Ed.2d 41 (1984)); *Collins v. King*, 743 F.2d 248, 251 (5th Cir.1984); *Heath v. Cleary*, 708 F.2d 1376, 1379 (9th Cir.1983); *Owen v. Kimmel*, 693 F.2d 711, 714 (7th Cir.1982). There is no suggestion in any of these cases that provision for administrative

review by the state constitutes the implicit creation of an exhaustion requirement.

Courts can find implicit requirements of exhaustion of remedies. But implicit does not mean created of whole cloth. There must at least be some clearly evident indication from Congress that that is its intent. We find none here, and accordingly the trial court must be reversed.

B. Exhaustion of Judicial Remedies:

Finally, Alacare argues that even if it is required to exhaust its state administrative remedies, it has already done so. The only thing it has not exhausted is its state judicial remedy. It has an action pending currently in Tallapoosa Circuit Court. The appellant argues that even if there is an implicit congressional intent to require exhaustion of administrative remedies, Congress clearly did not intend to require exhaustion of judicial remedies and thus there can be no implicit requirement that this second layer of relief be pursued. Appellant notes further that the Medicaid Act does not require that a state open its courts to such claims and, since not all states do so, to require exhaustion of judicial remedies imposes an uneven burden on litigants in the various states.

The appellee's response is that Alacare should not be heard to complain because it elected to pursue its state judicial remedy and hence should be forced to see it through. Appellee also submits that we should invoke the abstention doctrine as articulated in *Colorado River Water Conservation District v. United States*, 424 U.S. 800, 96 S.Ct. 1236, 47 L.Ed.2d 483 (1976), and decline to consider the merits.

The short answer to the former argument is to note that the appellant only "elected" to pursue a state court remedy because it constitutes part of the prescribed ave-

nue of relief under the Alabama Medicaid statute. Ala. Code § 41-22-20 (1975). The short answer to the latter argument is to note that *Colorado River Water District* has been rejected as a basis for abstention under Section 1983 in this Circuit. *Forehand v. First Alabama Bank of Dothan*, 727 F.2d 1033, 1036 (11th Cir. 1984) ("There is no such congressional statement . . . that Sec. 1983 plaintiffs should be required to litigate their federal claims in state forums [sic] when actions involving the same transaction are pending in state court. If there is any presumption on this point, it would tend to run in the opposite direction.").

More importantly, the Supreme Court and this and other appeals courts have all held that the no-exhaustion rule applies to exhaustion of state administrative *and* judicial remedies. *See e.g., Steffel v. Thompson*, 415 U.S. 452, 472, 94 S.Ct. 1209, 1222, 39 L.Ed.2d 505 (1974) ("When federal claims are premised on 42 U.S.C. § 1983 . . . we have not required exhaustion of state judicial or administrative remedies. . . ."); *McNeese v. Board of Education*, 373 U.S. 668, 671-72, 83 S.Ct. 1433, 1435-36, 10 L.Ed.2d 622 (1963) (same); *Gilmere v. City of Atlanta*, 774 F.2d 1495, 1499 (11th Cir. 1985) (*en banc*) ("[T]he right to bring an action under section 1983 need not depend on the exhaustion of state judicial or administrative procedures. . . . [A]ccess to federal court under section 1983 is not in general predicated on actual proof of a failure of the state adjudicatory system."); *Lewis v. Hillsborough Transit Authority*, 726 F.2d at 669 (no exhaustion requirement except as provided in CRIPA); *McKinnis v. Mosely*, 693 F.2d 1054, 1056 (11th Cir. 1982) (*per curiam*) (same); *Loudermill v. Cleveland Board of Education*, 721 F.2d 550, 555 (6th Cir. 1983) (*McNeese* made clear there is no judicial exhaustion requirement, and *Patsy* "left little room" for one.),[4] *aff'd*

[4] *See also, Loudermill*, 721 F.2d at 555 n.5 (court declines to find implicit requirement of judicial exhaustion because "we find

on other grounds, —— U.S. ——, 105 S.Ct. 1487, 84 L.Ed.2d 494; *Daniels v. Williams*, 720 F.2d at 794 n.1 (same). The courts have not drawn a distinction between requirements of exhaustion of administrative versus judicial remedies. Accordingly, this question turns on the result this Court reaches in Section A, *supra*; hence the trial court was in error.

Even if we elect to treat the two exhaustion requirements independently, and accepting *arguendo* that administrative exhaustion is desirable and ought to be required, this does not support a judicial exhaustion requirement for two reasons. First, the benefit of requiring administrative exhaustion is that it gives the parties and the court the benefit of the agency's longstanding expertise with the intricacies of statutes like Medicaid. The same does not hold for requiring exhaustion of state court remedies.

More importantly, if we were to require exhaustion of judicial remedies, the doctrine of *res judicata* and collateral estoppel would mean that an unfavorable state court opinion would have issued preclusive effects that would bar the party from relitigating his claim in federal court—eviscerating the supplemental nature of Section 1983. *Loudermill*, 721 F.2d at 555 & n.6; *The Supreme Court, 1981 Term*, 96 Harv. L. Rev. 62, 210 (1982); Comment, *Exhaustion of State Administrative Remedies in Section 1983 Cases*, 41 U. Chi. L. Rev. 537, 541 (1974). A decision by an administrative agency would of course not have this preclusive effect. Requiring exhaustion of state court remedies is both obviously undesirable and inconsistent with the well-settled desire of Congress to promote "the free, unimpeded resort to

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that such an exception would be inappropriate in the instant cases where appellants exhausted their administrative remedies. The Courts have never even intimated that exhaustion of state judicial remedies in § 1983 cases should be required, as it is in habeas corpus cases.").

1983." *Patsy*, 457 U.S. at 509, 102 S.Ct. at 2564 (quoting Rep. Kastenmeier). Accordingly, it was error for the trial court to impose such a requirement.

III.

For the reasons foregoing, we hold that the trial court was correct in finding that there may be implicit exceptions to the rule of *Patsy*. But we determine that the trial court was incorrect in finding the existence of such an exception in the language of the Medicaid Act. Likewise, the trial court was incorrect in imposing a requirement that the appellant exhaust available state judicial remedies. Accordingly, it was error to grant the motion for summary judgment.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED FOR TRIAL.

APPENDIX B

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 85-7420

ALACARE, INC.—NORTH, an Alabama corporation,
Plaintiff-Appellant,

versus

FAYE S. BAGGIANO, in her official capacity as commissioner of the Alabama Medicaid Agency,
Defendant-Appellee,

ALABAMA MEDICAID AGENCY,
Defendant.

Appeal from the United States District Court for the Middle District of Alabama

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ORDER

( ) The motion of appellee, Faye S. Baggiano for ☒ stay ☐ recall and stay of the issuance of the mandate pending petition for writ of certiorari is DENIED.

(X) The motion of appellee, Faye S. Baggiano for ☒ stay ☐ recall and stay of the issuance of the mandate pending petition for writ of certiorari is GRANTED to and including May 22, 1986, the stay to continue in force until the final disposition

of the case by the Supreme Court, provided that within the period above mentioned there shall be filed with the Clerk of this Court the certificate of the Clerk of the Supreme Court that the certiorari petition has been filed. The Clerk shall issue the mandate upon the filing of a copy of an order of the Supreme Court denying the writ, or upon the expiration of the stay granted herein, unless the above mentioned certificate shall be filed with the Clerk of this Court within that time.

( ) The motion of ———— for a further stay of the issuance of the mandate is GRANTED to and including ————, under the same conditions as set forth in the preceding paragraph.

( ) IT IS ORDERED that the motion of ———— for a further stay of the issuance of the mandate is DENIED.

/s/ James M. Johnson, Sr.
United States Circuit Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

Civil Action No. 85-H-262-N

ALACARE, INC.—NORTH, an Alabama corporation,
Plaintiff

vs.

FAYE S. BAGGIANO, in her official capacity as commissioner of the Alabama Medicaid Agency and the ALABAMA MEDICAID AGENCY,
Defendants

[Filed May 3, 1985]

ORDER

Plaintiff Alacare, Inc.—North brought this action under 42 U.S.C. § 1983 against the Alabama Medicaid Agency (Agency) and against Faye Baggiano, in her official capacity as Commissioner of the Agency. Plaintiff alleges that defendants have refused to enter into a contract with it for the provision of "skilled" medical care. This refusal to contract, alleges plaintiff, has deprived it of procedural and substantive due process, and equal protection under law, as guaranteed by the Fifth and Fourteenth Amendments to the United States Constitution. Defendants have filed motions to dismiss which are presently before the Court. Because reference was made to matters outside the pleadings, the Court will treat said motions as motions for summary judgment.

FACTS

Plaintiff operates the Adams Nursing Home located in Alexander City, Alabama. The United States Department of Health and Human Services had, at an earlier date, accepted Adams as an "intermediate care facility" for the purpose of receiving reimbursement from the Alabama Medicaid Agency under the Federal Medicaid Act, 42 U.S.C. § 1396 *et seq.* As an "intermediate care facility," Adams was entitled to provide care to patients suffering from chronic illness or aging and to be reimbursed pursuant to a contract with the State.

Effective February, 1984, Health and Human Services upgraded Adams' classification to that of a "dual care facility." This meant that Adams was entitled to provide both intermediate and skilled care to Medicaid patients, at a level of care similar to that provided to a hospital patient. Plaintiff alleges that, notwithstanding its certification as a dual care facility, the Agency refused to contract with it for the provision of skilled care.

Plaintiff contested this decision at an administrative hearing, but its claim was denied. Pursuant to *Ala. Code* § 41-22-30 (1975), plaintiff filed a petition in the Circuit Court of Tallapoosa County, Alabama, requesting judicial review of this decision. Plaintiff also filed the present action, seeking a declaratory judgment to the effect that defendants' failure to enter into this agreement violates federal and state law. In addition, plaintiff seeks "equitable restitution" from defendants for the cost of providing skilled care in the absence of this agreement.

CONCLUSIONS OF LAW

The Court agrees with the proposition advanced by defendants that plaintiff's claim for restitution from both defendants "is in essence one for the recovery of money from the State. . . ," *Ford Motor Co. v. Dept. of Treasury*, 323 U.S. 459, 464 (1945), so that plaintiff's claim

for monetary relief is barred by the Eleventh Amendment to the United States Constitution. The Court, however, will address at greater length defendants' contention that this action should be dismissed because of plaintiff's failure to exhaust its administrative remedies, because the Court finds this issue to be dispositive of the entire case.

The exhaustion of state judicial or administrative remedies is generally not required in order to maintain an action under § 1983. *Patsy v. Board of Regents*, 457 U.S. 496 (1982). In *Patsy*, the Court noted that courts should refer to congressional intent in determining whether exhaustion is required:

> Even where the statutory requirement is not explicit, courts are guided by congressional intent in determining whether application of the [exhaustion] doctrine would be consistent with the statutory scheme . . . With state administrative remedies, the focus is not so much on the role assigned to the state agency, but the role of the state agency becomes important once a court finds that deferring its exercise of jurisdiction is consistent with statutory intent.

Id. at 504, n.4.

The congressional intent regarding the administration of the Medicaid Act is clear. The Act directs the State to administer the Medicaid program on the state level. 42 U.S.C. § 1396a (1-5). Pursuant to this statute, and in accordance with the Alabama Administrative Procedure Act, *Ala. Code* § 41-22-1, *et seq.* (1975), the State of Alabama has established the Alabama Medicaid Administrative Code. Rules 560-x-3-.01 through 560-x-3-.07 of the Code recognize the right of a party to an administrative hearing, and provide for the right to appeal an adverse administrative decision. *See* Alabama Administrative Procedure Act, *Ala. Code* § 41-22-20 (1975). As noted above, plaintiff has availed itself of this appeal

provision by petitioning for judicial review of the Agency's determination before the Circuit Court of Tallapoosa County.

In light of the administrative framework established under the Medicaid Act, the Court is of the opinion that plaintiff should pursue the remedies provided by state law before instituting an action in federal court. If the Court were to accept plaintiff's arguments to the contrary, the exhaustion requirement embodied in the Federal Medicaid Act and the State Administrative Procedure Act would be reduced to a meaningless charade by merely "crying 1983." *St. Joseph Hospital v. Electronic Data Systems*, 573 F. Supp. 443, 450 (D.C. Tex. 1983). Accordingly, it is

ORDERED that defendants' motions for summary judgment are granted, and this cause is dismissed without prejudice.

DONE this 3rd day of May, 1985.

/s/ Truman Hobbs
United States District Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

Civil Action No. 85-H-262-N

ALACARE, INC.—NORTH, an Alabama corporation,
Plaintiff

vs.

FAYE S. BAGGIANO, in her official capacity as commissioner of the Alabama Medicaid Agency and the ALABAMA MEDICAID AGENCY,
Defendants

[Filed June 28, 1985]

ORDER

On May 3, 1985, this Court treated defendants' motions to dismiss as motions for summary judgment because reference was made to matters outside the pleadings. The Court granted defendants' motions for summary judgment because it found that plaintiff had failed to exhaust the remedies available to it in the administrative system established pursuant to the Medicaid Act. Plaintiff filed a motion for reconsideration of this Order on May 15, 1985, and requested an opportunity to present evidence to the Court regarding the issues raised in defendants' motion. The Court allowed both parties an opportunity to present such evidence.

In support of its motion for reconsideration, plaintiff filed a copy of the deposition of Henry LeCroy, the Director of the Alabama Medicaid Agency's Division of Long-Term Care. Upon consideration of this deposition and the accompanying briefs of counsel, the Court finds that plaintiff has failed to show that the exhaustion requirement should be waived in this case. Plaintiff has failed to show, for example, that exhaustion would be futile. *Hudson v. Farmers Home Administration*, 654 F.2d 334 (5th Cir. 1981). Accordingly, plaintiff's motion for reconsideration is denied.*

The Court grants plaintiff's request, however, to toll the applicable statute of limitations until the state administrative appeals established pursuant to the Medicaid Act have been exhausted.

DONE this 28th day of June, 1985.

/s/ Truman Hobbs
United States District Judge

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*The Court would add, however, that based upon the materials submitted to the Court to date, if the Court were to reach the merits of plaintiff's claim under 42 C.F.R. 442.12(d), it would find that defendant Agency had good cause to refuse to execute an agreement with plaintiff.

APPENDIX E

42 U.S.C. § 1983

§ 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

APPENDIX F

THE MEDICAID ACT

42 U.S.C. § 1396a

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter, and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the back of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration including methods relating to the establishment and maintenance of personnal standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accord-

ance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan as are found by the Secretary to be necessary for the proper and efficient operation of the plan. (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time, or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207, or 208 of Title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan: or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI

of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services.

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (11) and (12) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, IX, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) or 606(h) of this title, or considered by the State to be receiving such aid as authorized under section 614(g) of this title).

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title;

(ii) at the option of the State, to any groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be).

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure.

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law.

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of

this chapter, or a State supplementary payment:

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title, or

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1396n(c) of this title they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1396n(c) of this title;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance

made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but

for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this

title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10, require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A) and (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396*o*(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption;

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance

under the plan, and (B) effective July 1, 1969, provide, to the extent prescribed the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting

the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiency and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports;

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(*o*) of this title; and

(C) for payment for services described in section 1396d(a)(2)(B) of this title provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1395*l*(a)(3) of this title, or, in the

case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396*o* of this title;

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under

subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions that provide for individuals under alternate plans of care, and arrangements, providing for access to parties and members. In [illegible].

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of

available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) of this title, or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out:

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods

that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) except as provided in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan arising out of injury, disease, or disability. (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17) (B), and (C) that in any case where such a legal liability

is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement in the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide—

(A) with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A)

to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases shall not apply for purposes of this subchapter;

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30) (A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care;

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, skilled nursing facility, intermediate care facility, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional

personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, skilled nursing facility, intermediate care facility, or hospital for mental diseases;

(3) with respect to skilled nursing facility services (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of

the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each skilled nursing or intermediate care facility within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise: except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employ-

ment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide

with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this title) receiving pay-

ments under such plan complies with the requirements of section 1320a-3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practioner or a group of practitioners) that

furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor;

(39) provide that the State agency shall bar any specified person from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 of this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such person during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or

otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action;

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper paymenets are made under the plan, (B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such subchapter, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1320a-8(a) of this title;

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(a)(4)(B) of this title,

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services;

(44) in each case for which payment for inpatient hospital services, skilled nursing facility services, intermediate care facility services, or inpatient mental hospital services is made under the State plan—

(A) a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b (g) (6) of this title (or, in the case of services that are intermediate care facility services provided in an institution for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title; and

(46) provide that information is requested and exchanged for purposes of income and eligibility vertificaiton in accordance with a State system which meets the requirements of section 1320b-7 of this title.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which

administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter for subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(b) Approved by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Reduction of aid or assistance under State plans under other subchapters

Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan (or medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid of assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter.

(d) Performance of medical or utilization review functions

If a State contracts with a utilization and quality control peer review organization having a contract with the Secretary under part B of subchapter XI of this chapter for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such organization (or organizations) under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by such organization (or organizations) as the Secretary may prescribe.

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

(1) Notwithstanding any other provision of this subchapter, effective January 1, 1974, each State plan approved under this subchapter must provide that each family which was receiving and pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(2) (A) In the case of an individual who is enrolled with a qualified health maintenance organization (as defined in Title XIII of the Public Health Service Act [42 U.S.C.A. § 300e et seq.]) under a contract described in section 1396b(m)(2)(A) of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such organization.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an

individual's enrollment with a health maintenance organization under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization becomes effective.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1382c(a) of this title;

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible to have a supplemental security income (or State supplemental) payment made with respect to him under subchapter XVI of this chapter,

shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter XVI of this chapter.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the

child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains eligible for such assistance.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10) (C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section con-

cerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Repealed. Pub. L. 96-499, Title IX, 913(d), Dec. 5, 1980, 94 Stat. 2620

(h) Repealed. Pub. L. 97-35, Title XXI, § 2173(b)(1), Aug. 13, 1981, 95 Stat. 809

(i) Termination of certification for participation of State payments to skilled nursing facilities and intermediate care facilities

(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1395x(j) of this title or section 1396d(c) of this title, respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1395x(j) of this title or section 1396d(c) of this title (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1395x(j) of this title or section 1396d(c) of this title (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Waiver or modification of requirements of this title with respect to medical assistance program in American Samoa

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(c) of this title, or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa for care and services described in paragraphs (1) through (18) of section 1396d(a) of this title.

APPENDIX G

ALABAMA MEDICAID ADMINISTRATIVE CODE
Chapter 3 Fair Hearings

Rule No. 560-X-3-.01. ***Fair Hearings—General***

(1) The State Plan provides that the office of the Governor acting through Medicaid, will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. An opportunity for a fair hearing shall be granted to any individual or provider of services requesting a hearing because a claim for medical assistance or payment for services provided a recipient is denied or is not acted upon with reasonable promptness, or because the party is aggrieved by any other agency action regarding receipt of medical assistance or payment for services, or by an agency policy as it affects the situation, except as noted in paragraphs 3 and 4 below.

(2) The Hearing Authority for all recipient and provider fair hearings for Alabama Medicaid Agency is the Commissioner who shall appoint one or more Hearing Officers, to conduct fair hearings and submit findings and recommendations to the Commissioner for final decision on each case. The Hearing Officer must not have been involved in any way with the action in question.

(3) In general, eligibility for Medicaid is based on eligibility for certain public assistance programs administered by the Department of Pensions and Security, and the Social Security Administration. Complaints concerning eligibility matters shall be referred to the appropriate agency which made the eligibility determination for a hearing. Procedures shall be set by the hearing agency.

(4) Matters pertaining to hospital or nursing home decertification for *both* Title XVIII and XIX will be referred to the Federal Health and Human Services Di-

rector for Health Standards and Quality in Region IV. His office is responsible for making final decisions on *joint* program decertification.

Authority: State Plan; Title XIX of the Social Security Act. Rule effective October 1, 1982. Effective date of amendment June 23, 1983.

Rule No. 560-X-3-.02. *Fair Hearings—Definitions.*

(1) A fair hearing is a face-to-face hearing by an impartial State Hearing Officer at a time and place reasonably convenient for the complainant and attended by the complainant or his authorized representatives who may call witnesses or examine witnesses called by others.

Authority: Section 1902(a)(3), Title XIX of the Social Security Act; 42 CFR § 431.200 thru 431.245 and Section 41-22-12, Alabama Administrative Procedure Act. Rule effective October 1, 1982. Amended August 9, 1984. Effective date of amendment January 1, 1986.

Rule No. 560-X-3-.03. *Fair Hearing Procedures for Recipients and Providers.*

(1) The procedures contained herein have been adopted by Medicaid to settle formal complaints of persons who are receiving care under the Medicaid program or who have been denied care under this program because of eligibility standards, or for providers who desire a fair hearing upon denial of a claim for services, out-dated claim and non-renewal or termination of a contract. At the request of a provider, the Commissioner may grant a fair hearing on any other matter pertinent to Medicaid.

(2) Except where the Secretary of Health and Human Services had determined that a provider must be removed from the program for abuse, the Commissioner of Medicaid shall, in writing, offer a provider a fair hearing prior to suspension or termination from the Alabama Medicaid

Program. If the provider does not respond within 10 days of the written offer he will be terminated from the program without further action.

(3) When provider criminal fraud is suspected, the Commissioner shall cause her/his appropriate staff to consult with the Office of the Attorney General prior to offering a fair hearing for termination purposes.

(4) A complainant, or authorized person acting for him, may request a fair hearing in writing if he is not satisfied with actions taken that relate specifically to himself. Persons desiring a hearing within the jurisdiction of Medicaid will be referred to the Director, Hearings, for appropriate scheduling.

(5) Except for the specific situations outlined below a written request for a fair hearing must be received by Medicaid within 60 days following the notice of action which prompts a claimant to request a hearing. Medicaid will not accept requests for fair hearings which are outside the 60 day limit. The exceptions to the 60 day limit are as follows:

(a) In a case in which Medicaid is terminating recipient eligibility, if a hearing request is received within 10 days of the date of the notice of action, benefits may be continued pending outcome of the hearing unless there are unnecessary delays in finalizing the hearing caused by the recipient or the recipient's representative.

(b) In a case in which Medicaid is suspending or terminating a Medicaid provider, if a hearing request is received within 10 days of receipt of the notice of termination, the provider may continue to remain as a Medicaid provider pending outcome of the hearing, unless there are unnecessary delays in finalizing the hearing caused by the provider or the provider's representative.

Authority: State Plan, Title XIX of the Social Security Act. 42 C.F.R. § 401, *et seq.* Rule effective October 1,

1982. Amended April 11, 1985. Effective date of amendment January 1, 1986.

Rule No. 560-X-3-.04. *Fair Hearing Procedures.*

(1) A hearing shall be impartially conducted and held at a time and place which is reasonably convenient for the parties, and written notice of such time and place shall be given by the Director, Hearings, or the designated Hearing Officer, at least 10 (10) calendar days before the hearing is to be held. This written notice will also contain information explaining the complaint's rights and procedures regarding a hearing.

(2) A complainant may be represented or assisted by legal counsel at his own expense; he may have a friend or relative present his case; or he may present his case himself.

(3) A complainant or his representative must attend his hearing unless he is given written permission by appropriate authority to be absent. His failure to attend shall leave the Hearing Officer with no alternative but to proceed with the hearing and render a conclusion and recommendation in his absence based upon evidence presented by the Alabama Medicaid Agency representatives.

(4) The complainant and/or his authorized representative may call witnesses, and may examine witnesses called by others.

Authority: Section 1902(a)(3), Title XIX, Social Security Act; 42 CFR, 431.200 thru 431.245, and Section 41-22-12, Alabama Administrative Procedure Act. Rule effective October 1, 1982. Effective date of amendment August 9, 1984.

Rule No. 560-X-3-.05. *Reserved.*

Rule No. 560-X-3-.06. *Action by Agency On Hearing.*

(1) Prompt, definitive, and final administrative action will be taken within sixty (60) days between the request for a hearing and the rendering of the decision, unless there are extenuating circumstances that require additional time. If the hearing is not completed within sixty days, the recipient or provider will be notified of the reason for the delay. In any event, final administrative action will be taken within ninety (90) days from the date of request for a hearing. The complainant will receive written notification of the decision.

(2) Recommendations of the Hearing Officer shall be based exclusively on evidence and other material introduced at the hearing. A verbatim transcript of testimony and exhibits, or an official report by the Hearing Officer containing the substance of what transpired at the hearing, together with all papers and requests filed in the proceeding and the Hearing Officer's recommendations, shall constitute the exclusive record for decision on a live hearing and shall be available to the complainant at any reasonable time. The storage, proper maintenance and security of such records shall be the responsibility of the Director, Hearings, Alabama Medicaid Agency.

(3) Adverse decisions approved by the Commissioner, as the hearing authority, shall contain a statement that rehearing and/or judicial review of this decision is available pursuant to the provisions of the Alabama Administrative Procedure Act. The Commissioner shall notify the requestor, in writing regarding the hearing decision.

Authority: Section 1902(a)(3), Title XIX of the Social Security Act; 42 CFR, § 431.200 thru 431.245, and Section 41-22-17, Alabama Administrative Procedure Act. Rule effective October 1, 1982. Amended August 9, 1984. Effective date of amendment January 1, 1986.

Rule No. 560-X-3-.07. *Denial of a Hearing.*

(1) If the request for a hearing, in the opinion of Medicaid legal counsel, presents only a legal issue, and the validity of the controlling law or regulation is not challenged in the hearing request, a fair hearing request may be denied.

(2) If eligibility of a provider or a recipient has been terminated because of a criminal conviction for Medicaid fraud or abuse, or if a provider has been terminated because of loss of required licensure, then no fair hearing need be given. A certified copy of the judgment of conviction or of the decision to revoke or suspend a provider's license shall be conclusive proof of ineligibility for further participation in the Medicaid Program. The pendency of an appeal for any such conviction or license revocation or suspension shall not abate the termination of Medicaid eligibility. If a conviction, or license revocation or suspension is reversed on appeal, the recipient or provider may apply for reinstatement to the Medicaid program. However, the reasons for the reversal will be scrutinized by Medicaid and reinstatement will be at the sole discretion of the Commissioner.

Authority: State Plan, Title XIX of the Social Security Act. 42 C.F.R. § 401, *et seq.*

APPENDIX H

§ 41-22-20. Judicial review of preliminary, procedural, etc., actions or rulings and final decisions in contested cases.

(a) A person who has exhausted all administrative remedies available within the agency (other than rehearing) and who is aggrieved by a final decision in a contested case is entitled to judicial review under this chapter. A preliminary, procedural, or intermediate agency action or ruling is immediately reviewable if review of the final agency decision would not provide an adequate remedy.

(b) Except in matters for which judicial review is otherwise provided for by law, all proceedings for review shall be instituted by filing of notice of appeal or review and, where required by statute, a cost bond, with the agency. A petition shall be filed in the circuit court of the county in which the agency maintains its headquarters, or unless otherwise specifically provided by statute, where a party (other than an intervenor) resides or if a party other than an intervenor), is a corporation, domestic or foreign, having a registered office or business office in this state, then in the county of such registered office or principal place of business within this state.

(c) The filing of the notice of appeal or the petition does not itself stay enforcement of the agency decision. If the agency decision has the effect of suspending or revoking a license, a stay or supersedeas shall be granted as a matter of right upon such conditions as are reasonable, unless the reviewing court, upon petition of the agency, determines that a stay or supersedeas would constitute a probable danger to the public health, safety, or welfare. In all other cases, the agency may grant, or the reviewing court may order, a stay upon appropriate terms, but, in any event, the order shall specify the conditions upon which the stay or supersedeas is granted;

provided, however, if the appeal or proceedings for review to any reviewing court are from an order of the agency increasing or reducing or refusing to increase rates, fares or charges, or any of them, or any schedule or parts of any schedule of such rates, fares or charges, the reviewing court shall not direct or order a supersedeas or stay of the action or order to be reviewed without requiring, as a condition precedent to the granting of such supersedeas, that the party applying for supersedeas or stay shall execute and file with the clerk of said court a bond as provided for and required by statute or law. If the circuit court shall fail or refuse to grant supersedeas or stay, the party seeking such relief may petition the court of civil appeals or the supreme court to order a supersedeas or stay of the action or order of the agency from which review is sought. After the required bond shall have been filed and approved by the clerk, such agency order shall be stayed and superseded, and it shall be lawful to charge the rates, fares or charges which have been reduced, refused or denied by said agency order, until the final disposition of the cause. The provisions of this subsection shall apply when applicable, anything in Rule 60 of the Alabama Rules of Civil Procedure restricting the provisions of this subsection to the contrary notwithstanding.

(d) The notice of appeal or review shall be filed within 30 days after the receipt of the notice of or other service of the final decision of the agency upon the petitioner or, if a rehearing is requested under section 41-22-17, within 30 days after the decision thereon. The petition for judicial review in the circuit court shall be filed within 30 days after the filing of the notice of appeal or review. Copies of the petition shall be served upon the agency and all parties of record after the petition is filed with the court. Any party to the agency proceeding may become a party to the review proceedings by notifying the court within 30 days after receipt of the copy of the petition. Any person aggrieved may petition to become

a party by filing a motion to intervene as provided in section 41-22-14. Failure to file such petition within the time stated shall operate as a waiver of the right of such person to review under this chapter, except that for good cause shown, the judge of the reviewing court may extend the time for filing, not to exceed an additional 30 days, or, within four months after the issuance of the agency order, issue an order permitting a review of the agency decision under this chapter notwithstanding such waiver.

(e) If there has been no hearing prior to agency action and the reviewing court finds that the validity of the action depends upon disputed facts, the court shall order the agency to conduct a prompt fact-finding proceeding under this chapter after having a reasonable opportunity to reconsider its determination on the record of the proceedings.

(f) Unreasonable delay on the part of an agency in reaching a final decision shall be justification for any person whose rights, duties, or privileges are adversely affected by such delay to seek a court order compelling action by the agency.

(g) Within 30 days after receipt of the notice of appeal or within such additional time as the court may allow, the agency shall transmit to the reviewing court the original or a certified copy of the entire record and transcript of the proceedings under review. With the permission of the court, the record of the proceedings under review may be shortened by stipulation of all parties to the review proceedings. Any party found by the reviewing court to have unreasonably refused to stipulate to limit the record may be taxed by the court for such additional costs as may be occasioned by the refusal. The court may require or permit subsequent corrections or additions to the record when deemed desirable.

(h) The petition for review shall name the agency as respondent and shall contain a concise statement of:

(1) The nature of the agency action which is the subject of the petition;

(2) The particular agency action appealed from;

(3) The facts and law on which jurisdiction and venue are based;

(4) The grounds on which relief is sought; and

(5) The relief sought.

(i) In proceedings for judicial review of agency action in a contested case, however, a reviewing court shall not itself hear or accept any further evidence with respect to those issues of fact whose determination was entrusted by law to the agency in that contested case proceeding; provided, however, that evidence may be introduced in the reviewing court as to fraud or misconduct of some person engaged in the administration of the agency or procedural irregularities before the agency not shown in the record and the affecting order, ruling or award from which review is sought, and proof thereon may be taken in the reviewing court. If, before the date set for hearing a petition for judicial review of agency action in a contested case, it is shown to the satisfaction of the court that additional evidence is material and that there were good reasons for failure to present it in the contested case proceeding before the agency, the court may remand to the agency and order that the additional evidence be taken before the agency upon conditions determined by the court. The agency may modify its findings and decision in the case by reason of the additional evidence and shall file that evidence and any modification, new findings, or decision with the reviewing court and mail copies of the new findings or decision to all parties.

(j) The review shall be conducted by the court without a jury and shall in the review of contested cases be confined to the record and such additions thereto as may be made under subsection (i) of this section. The court,

upon request, shall hear oral argument and receive written briefs.

(k) The agency order shall be taken as prima facie just and reasonable and the court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact, except where otherwise authorized by statute. The court may affirm the agency action or remand the case to the agency for taking additional testimony and evidence or for further proceedings. The court may reverse or modify the decision or grant other appropriate relief from the agency action, equitable or legal, including declaratory relief, if the court finds that the agency action is due to be set aside or modified under standards set forth in appeal or review statutes applicable to that agency, or where no such statutory standards for judicial review are applicable to the agency, if substantial rights of the petitioner have been prejudiced because the agency action is:

(1) In violation of constitutional or statutory provisions;

(2) In excess of the statutory authority of the agency;

(3) In violation of any pertinent agency rule;

(4) Made upon unlawful procedure;

(5) Affected by other error of law;

(6) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(7) Unreasonable, arbitrary or capricious or characterized by an abuse of discretion or a clearly unwarranted exercise of discretion.

(*l*) Unless the court affirms the decision of the agency, the court shall set out in writing, which writing shall become a part of the record, the reasons for its decision (Acts 1981, No. 81-855, p. 1534, § 20.)

85-2152

No. 85-2125

Supreme Court, U.S.
FILED
JUL 29 1986
JOSEPH F. SPANIOL JR.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

FAYE S. BAGGIANO, IN HER OFFICIAL CAPACITY, AS COMMISSIONER OF THE ALABAMA MEDICAID AGENCY, AND THE ALABAMA MEDICAID AGENCY,
Petitioners,

v.

ALACARE, INC.-NORTH, AN ALABAMA CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF IN OPPOSITION

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

No. 82-2125

FAYE S. BAGGIANO, IN HER OFFICIAL CAPACITY, AS COMMISSIONER OF THE ALABAMA MEDICAID AGENCY, AND THE ALABAMA MEDICAID AGENCY,
Petitioners,

v.

ALACARE, INC.-NORTH, AN ALABAMA CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF IN OPPOSITION

SUMMARY OF ARGUMENT

The petition for a writ of certiorari does not point to any compelling reason why this Court should address the issue sought to be raised. The question of exhaustion of state remedies as a prerequisite to actions under 42 U.S.C. § 1983 has been fully and adequately dealt with by this Court, and the decision below is consistent with the precedent announced by this Court.

The petition does not assert any appropriate ground under Rule 17 of the Rules of the Supreme Court of the United States sufficient to justify the issuance of a writ of certiorari in this case.

ARGUMENT[1]

The petition for a writ of certiorari in this cause does not assert any of the Rule 17 reasons customarily relied upon by the Court for the granting of a writ. The decision below (*AlaCare, Inc.-North v. Baggiano*, 785 F.2d 963 [11th Cir. 1986]) is not shown to be in conflict with a decision of another federal court of appeals on the same matter,[2] nor is the decision shown to constitute a departure from the accepted and usual course of judicial proceedings. While the decision did involve an important question of federal law, it cannot be said either that the issue here raised has not been settled by this Court or that the Eleventh Circuit decision is in conflict with applicable decisions of this Court.

The Petitioners maintained below that *Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496 (1982), did not prevent a finding of an implied exhaustion requirement for Medicaid actions under 42 U.S.C. § 1983. Both the district court (App. to Petition, 20a-21a) and

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[1] In compliance with the requirements of Rule 28.1 of the Rules of the Supreme Court of the United States, the Court is advised that the parent corporation of AlaCare, Inc.-North is Age, Inc. Corporations affiliated with the Respondent are Cullman Nursing Services, Inc., Woodland Village Health Care Center, Inc., South Morgan Health Care, Inc., Haleyville Health Care Center, Inc., West Morgan Health Care Center, Inc., and Pike Health Services, Inc.

[2] On the contrary, in the only other federal circuit court of appeals case alluded to in the decision of the court below, which addressed the distinctions between Patsy v. Board of Regents of the State of Florida, 457 U.S. 496 (1982), and Fair Assessment in Real Estate Association v. McNary, 454 U.S. 100 (1981), the Sixth Circuit appears to have adopted the same rationale as did the Eleventh Circuit in the instant case. See Loudermill v. Cleveland Board of Education, 721 F.2d 550, 555, n. 5 (6th Cir. 1983), *aff'd on other grounds*, —— U.S. ——, 84 L.Ed. 2d 494, 105 S.Ct. 1487 (1985).

Neither the Sixth Circuit nor the Eleventh Circuit appears to have had any significant difficulty in construing the *Patsy* and the *McNary* cases and in harmonizing their teachings.

the Court of Appeals (785 F.2d at 966) agreed with the Petitioners upon this point. However, the Court of Appeals noted that "[t]he evidence of a congressional preference for imposing an exhaustion requirement in Medicaid cases is simply inevident, either explicitly or implicitly." 785 F.2d at 967. In view of *Patsy*, the Court of Appeals felt that "the presumption is *strongly* in favor of no exception." 785 F.2d at 967. The panel then reasoned that the congressional requirement that a state establish review machinery did not of itself evidence an intent to require exhaustion, because there is in almost every § 1983 case some alternate form of redress available at state law. If the availability of such alternate remedies were considered as bars to direct access to federal court under § 1983, the appeals court feared that the "result would be a major, dramatic narrowing of the scope of relief available under Section 1983." 785 F.2d at 968.

The court below alluded to, and rejected the reasoning in, two post-*Patsy* district court cases which held that state remedies established pursuant to congressional Medicaid requirements must be exhausted before litigants could resort to § 1983 claims. See *Arden House, Inc. v. Heintz*, 612 F.Supp. 81, 85 (D. Conn. 1985); *St. Joseph Hospital v. Electronic Data Systems Corp.*, 573 F.Supp. 443, 450 (S.D. Tex. 1983). In their petition filed in this Court, the Petitioners add one other such district court case. See *Al-Charles, Inc. v. Heintz*, 620 F.Supp. 327 (D. Conn. 1985). The Eleventh Circuit noted when this matter was before it that those courts simply reasoned that, since the Medicaid statute requires the creation of a state administrative process to review claims, the congress "must . . . have intended" that they be used prior to institution of a § 1983 claim. 785 F.2d at 967. Understandably, the Eleventh Circuit found this reasoning to be insufficient to satisfy the standards laid down by this Court in *Patsy*.

Apparently no other court of appeals besides the Eleventh Circuit has, since *Patsy*, addressed the specific

question of whether exhaustion of state remedies established pursuant to the Medicaid statute is a prerequisite to the institution of a § 1983 claim. The Fourth and Fifth Circuits seem to have assumed that exhaustion is not required in such cases. See *Randall v. Lukhard*, 709 F.2d 257, 261 (4th Cir. 1983), *aff'd and rev'd in part on other grounds*, 729 F.2d 966 (4th Cir. 1984) (*en banc*), *cert. denied*, —— U.S. ——, 83 L.Ed. 2d 152, 105 S.Ct. 222 (1984); *Curtis v. Taylor*, 625 F.2d 645, 649 (5th Cir. 1980), *modified on other grounds*, 648 F.2d 946 (5th Cir. 1980).

The district courts sitting outside the territory of the Eleventh Circuit which have addressed the exhaustion question in Medicaid cases generally do not appear to have adequately examined the legal question in the light of *Patsy*, and certainly they did not explore the *Patsy* teaching with the depth employed by the Eleventh Circuit in the instant case.

CONCLUSION

It is respectfully submitted that the petition for a writ of certiorari is due to be denied. The Petitioners have not revealed any compelling reason under Rule 17 why it should be granted. Additionally, it is submitted that the decision of the Eleventh Circuit Court of Appeals represents a correct application of the law as established by the precedent of the decisions of this Honorable Court.

Respectfully submitted,

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